Increasing Treatment Adherence Among Adults with Co-Occurring Psychiatric and Substance Use Disorders: The Role of Social Engagement

L. Davidson, D. Sells, D.A. Stayner, C. Barber, M. Delphin, and G. Shahar

Program for Recovery and Community Health

Yale University School of Medicine

Factors Influencing Adherence

Person Factors

- Substance use
- Side effects
- Denial of illness/ Lack of insight
- Cognitive and memory deficits
- Mistrust of mental health system

Social Factors

- Homelessness
- Unemployment
- Social isolation
- Demoralization
- Lack of hope
- Lack of sense of self-efficacy

Interventions to Increase Adherence

- Depot/injectable medication
- Symptom monitoring, early intervention, and relapse prevention
- Family-assisted symptom monitoring and relapse prevention
- MEMS caps (to augment skills training)

Development of Social Engagement Intervention

- Problem of inpatient recidivism in urban community mental health center
- Attempted symptom monitoring, early intervention, and relapse prevention approach developed by Birchwood et al.
- Robust finding after 3 months of 0% attendance in new program post-d/c
- Qualitative, participatory follow-up

Qualitative Interviews

- Interviewed 12 people with histories of inpatient recidivism following recent d/c
- Elicited descriptions of life before, during, and after recent admission and reasons for not participating after d/c
- Analyzed data according to established empirical-phenomenological method

Major Findings

- Hospitalization viewed as "vacation"
- Inpatient treatment seen as no more useful for participants than a history lesson
- Outpatient treatment seen as irrelevant to participants' lives in the community
- Lives in the community characterized by loneliness, poverty, unemployment, and absence of meaningful activities
- Key issues of demoralization, isolation, and lack of responsiveness in care

Participatory Process

- Involved participants in developing new interventions to target demoralization and isolation that also would address everyday life in the community
- Resulted in social engagement program run by people in recovery collaborating with clinical/rehab staff
- Two groups and one 'outing' per week
- Consultation to clinical providers and focus on engaging participants into treatment

INTERVENTIONS

Social Isolation to Social Support	Demoralization to Self-Efficacy	Disconnection from to Engagement in Treatment
1. Assist group members to engage in social connections with other group members. a. encourage members to share their experiences of social disconnection and isolation. b. assertive community outreach. c. provide transportation to groups for 3 months, and then as indicated. d. maintain twice-weekly personal contact with members for 3 months, then as indicated. e. assist members to get half-price bus passes. f. encourage members to accompany each other to assist in learning bus routes. 2. Facilitate and encourage specific acts of mutual support and reciprocity among members. a. encourage expressions of caring, camaraderie, and friendship among group members. b. assist members to recognize and respect social cues and personal boundaries in their interactions. c. 3 home visits are made to new members by peer support staff to provide home supplies and lists of local community resources, and to help members fill out personal interest inventories. 3. Facilitate local community outings and activities with group members. a. provide planning, financial support, and transportation for once-weekly, local community outings led by peer support staff. b. enhance members' independence, and familiarity and connections with affordable, local community activities and resources. 4. Create and maintain group celebrations. a. assist members to celebrate milestones in recovery and avoiding rehospitalization. b. enhance members' connections with seasonal rhythms, and with local events and celebrations. 5. Facilitate participative group planning to increase members' personal investment in upcoming meetings, activities, and events.	1. Assist group members to recognize and share problems they face, and changes that occur. a. encourage members' expressions of hope in the possibility of change and recovery. b. encourage members to recognize and share downward and upward social comparisons. c. encourage members to share their struggles with constricted resources and help them apply for needed assistance. 2. Facilitate participatory decision making and planning among group members. a. help members to recognize how their actions impact on the group and other members. b. help members make specific, constructive plans for unstructured time, such as weekends. c. strengthen experiences of mutual account-ability and responsibility among members. 3. Provide individually tailored, flexible support to group members experiencing crises: a. increase engagement and contact intensity. b. provide transportation to extra outpatient appointments and intermediate care facilities. c. provide clinicians with assessments of functional deterioration and crisis intensification. d. advocate for inter-treater meetings to plan special support and outreach efforts. 4. Facilitate the emergence and recognition of group members' natural interests. a. encourage members to state preferences and interests in participatory planning for meals, community outings, and in group celebrations. b. encourage members to initiate activities with others who share their interests. c. recognize members' particular strengths, skills and natural leadership roles in activities. d. recognize and encourage members to share ways their interests motivate initiative and enhance engagement in community activities.	1. Help group members to face symptoms and destructive patterns of relating as these become evident in the lived interactions of the group. 2. Help group members recognize changes and improvements in their symptoms and problems. 3. Connect group members with abstinence-based self-help groups for substance abuse. a. support members' engagement in these groups by rewarding it with positive group recognition. b. encourage members to connect with sponsors. c. assist members with transportation if indicated. d. facilitate group celebrations of turning points and milestones in recovery. 4. Assist group members to experience them-selves as collaborative partners in their care. a. help members to recognize their fears of medication side effects and stigma. b. train members in using the collaborative treatment planning workbook and offer to act as advocates on their behalf in treatment planning. c. assist members to honestly face struggles between acquiescence and compliance. 5. Assist group members to connect experienced stress with symptom exacerbation. a. facilitate problem solving to help members reduce the impact of some stressors. b. assist members to find activities and other strategies for reducing experienced stress. 6. Advocate for flexible, collaborative treatment planning with outpatient treaters and other service agencies. 7. Provide outpatient clinicians with information about members' daily lives and environment; cultural/racial/ethnic/gender/religious identity; and functional disabilities and strengths. 8. Consult to outpatient clinicians regarding frustration and demoralization around group members' continuing problems.

Table 2. Service Utilization for One Year Prior to Index Admission and 90 Days Post-Discharge

	1 Year Prior to Index Admission		90 Days Post-Discharge	
Variables	Engage + Standard Care	Usual Care Only	Engage + Standard Care	Usual Care Only
Mean Admissions per Patient	1.60	1.88	.13	.42
Mean Days Inpatient per Patient	30.80	35.08	.42	5.08

Table 3. Inpatient and Outpatient Service Utilization for Engage vs. Usual Care Only

Condition	Mean Inpatient Service Use 1 Year Prior	Mean Inpatient Service Use at 3 Months	Mean Outpatient Service Use at 3 Months	Mean Self-Help Use at 3 Months
Engage + Usual Care	.54 admissions 3.3 days inpatient	.5 admissions 4.4 days inpatient	44 hours	.78
Usual Care Only	.33 admissions 4.4 days inpatient	.75 admissions 5.2 days inpatient	10 hours	.30